2016 Benefits

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Benefits Guide

2016 BENEFITS GUIDE

INTRODUCTION

Employees have a wide range of competitive benefit programs focused on quality, customer service and enhanced use of technology tools for members. Our benefit programs promote the physical, emotional and financial health and well-ness of you and your covered family members and provide an important part of employee total compensation.

Some employee benefit programs are 100% funded by the City and provided automatically to eligible employees, while other benefit programs give eligible employees an "opt-in or opt-out" choice. Many benefit programs are effective as of your first day of employment with the City and some programs are effective as of the first of the month following your first day of employment. Now is the time to make enrollment decisions about "right plan, right price, right people and right time".

You will want to carefully review this guide to get more details about these exciting programs. Be sure to keep an eye on future benefit communications, for other information and updates as well.

PLANS & ELIGIBILITY INFORMATION

Benefit Options	F/T Employees	Benefit Eligible P/T Employees	Elected Officials	Spouse/Committed Partner & Dependent Children Eligible?
Medical/Prescription Drug Plans	Yes	Yes	Yes	Yes
Dental Plans	Yes	Yes	Yes	Yes
Vision Plans	Yes	Yes	Yes	Yes
EAP	Yes	Yes	Yes	Yes
Long Term Disability	Yes	Yes	Yes	No
Voluntary Short Term Disability	Yes	No	No	No
Basic Life and AD&D Insurance	Yes	No	Yes	No
Voluntary Supplemental Life Insur-ance	Yes	Yes	Yes	Yes
Business Travel Accident/Commuter Travel Life Insurance	Yes	No	Yes	No
Flexible Spending Accounts (FSA) Health and Dependent Care	Yes	Yes	Yes	No

ENROLLMENT CHECKLIST

The following is a checklist to help you keep track of what you need to do to enroll in City of Mesa Benefit Plans:

Review this guide and understand your options

- ☐ **Read this Guide** and be prepared to ask any questions that you have during your New Employee Orientation (NEO) meeting
- ☐ If you or any of your eligible dependents reside out-of-state for most of the year and you want the family to be enrolled in one of the City's Out-of-State Medical Plans (for access to in-network coverage on a national basis), **know and be prepared to provide you or your dependents' out-of-state address(es)**
- ☐ **Locate and bring** any applicable verification documents if you are intend to add spouse/Committed Partner or eligible dependents to any benefit plan coverage (e.g., marriage certificates, birth certificates, adoption/legal guardianship paperwork, Affidavit/ Declaration of Committed Partnership—form at following link: **AFFIDAVIT** and related verification documents, etc.) - see Dependent Eligibility section of this guide for additional information
- ☐ **Compare your costs** by evaluating you and your family's specific coverage needs between plan options e.g. do you need lower deductibles and specific copay arrangements or is a co-insurance plan with much lower premiums a better fit for your financial and coverage needs?

Enroll using eBenMesa

- ☐ During your NEO meeting, you will be provided with detailed information on how to **enroll using eBenMesa**, our online enrollment tool; you will also be asked to update your contact information via an online ESS application
- ☐ Be prepared to **upload/scan** any applicable verification documents if you are adding spouse, Committed Partner or eligible dependents to any benefit plan
- ☐ Be prepared to designate your Life Insurance **beneficiary designations**
- ☐ You may need to complete an **Enrollment and Statement of Health** (ESH) form for certain coverage amounts above the guaranteed issue levels for Supplemental Life Insurance on yourself or eligible dependents (see Life Insurance section of this guide for additional information); the ESH form can be found at the following link: **ESH Form**

Confirm your benefits elections—Final Submission

- ☐ Once you complete your enrollment during NEO, be sure to **review and verify** all your elections
- ☐ Be sure to **print or save** a copy of your **final submission** as proof and support of your elections in case you forget, or you need to advise other family members or in the unlikely event of a system error that you need to correct at a later date

Check your paystub

- ☐ Be sure to **check your paystub** after your benefits become effective to make sure your elections are accurately reflected—if you believe an error has occurred, call Employee Benefits immediately at 480.644.2299, Option # 9; have your printed final submission verification on hand as proof of your intended enrollment
- ☐ Look for your **new ID cards and Health FSA debit card** (if you enroll in the Health FSA), within 2 weeks of your effective date

HOW TO ENROLL IN CITY OF MESA BENEFIT PLANS

ACTION IS REQUIRED WITHIN SPECIFIC TIMELINES, BEFORE YOUR BENEFITS CAN BE ACTIVATED!!

Please review the entire workbook, complete the eBenMesa online enrollment process and scan/upload any required paperwork and documentation.

EBENMESA – ONLINE NEW HIRE BENEFITS ENROLLMENT

eBenMesa is a secure, self-service application that provides online enrollment processing for new hires (and any subsequent Open Enrollment process that generally occurs annually in early October). Plan for your New Hire Orientation (NEO) and come prepared to use eBenMesa to input your benefit enrollment elections. You will receive login information and assistance with the use of the enrollment application during NEO, but it is recommended that you already have an idea of the plans you want, eligible family members you want to enroll, questions that you need to ask, and bring any required documentation for dependent verification and other processes. See later sections of this workbook for details. You are required to actively enroll (or opt-out) of most of the benefit plans for which you are eligible and some plans are "auto-enrolled" for you.

Qualifying change event processing after your initial new hire enrollment is not currently available in eBenMesa - use forms/documents (which you can retrieve from the benefits website, scan/email, fax or mail delivery, until online change functionality is enabled in the eBenMesa application, later in 2016).

SUBMITTING REQUIRED VERIFICATION

The eBenMesa enrollment application allows you to scan/upload any required forms and documentation either when you are initially enrolling or later when you re-enter the online application tool. After you have scanned and saved your documents to your computer, logon to eBenMesa and choose the "File Upload" link on the Home Page. **You must complete and upload documentation within 31 days of your benefits effective date.**

WHEN DO BENEFITS BEGIN?

New employees may choose the date that medical, dental, vision and flexible spending account (FSA) coverage will begin. There are two benefit effective date options for these benefits.

Option 1: Benefits begin on your start date/hire date; you must complete the eBenMesa enrollment process and provide all required documentation on your hire date. **If the enrollment process is not completed and/or required documents are not submitted on your hire date then you will be defaulted to option two.**

Option 2: Benefits begin on the first day of the month following or coincident to your hire date (providing you have completed the eBenMesa enrollment process within 31 days of that "1st of the month" date. **This is the City's default option for benefits effective date.**

Long Term Disability coverage under ASRS or PSPRS is mandatory coverage for eligible employees (including any applicable ASRS employee contributions via payroll deductions) and will be effective on the employee's start date. Voluntary Short Term Disability and Supplemental Life insurance coverage if elected, is effective on the first of the month following the hire date, even if the hire date is on the first of a month.

PAYROLL DEDUCTIONS FOR BENEFIT COVERAGE

Premiums that you pay for your benefit elections are deducted from your pay checks on a 24-times per year basis - from the first two pay checks of each month for that month's coverage – with the exception of FSA and ASRS LTD deductions which are deducted from all paychecks. Deductions from pay for benefits that start on your hire date, are started on the first available pay check after processing is complete.

OTHER INSURANCE INFORMATION

If you or covered family members have other medical or dental insurance outside City of Mesa coverage (e.g. other employer coverage), you are required to provide this other insurance information to each plan's Third Part Administrator (TPA) - for timely and accurate claims coordination of benefits. You can proactively contact administrators and advise of your other insurance coverage. Be sure to respond timely to any request from a TPA to confirm or deny other insurance coverage (particularly for your dependents), so that your claims can be accurately administered.

OPTING OUT OF HEALTH COVERAGE

The City does not require you to prove/document you have other medical coverage if you are eligible and opt-out of the City's medical plans. However, Health Care Reform (the Affordable Care Act) mandates that every individual must have qualified medical insurance coverage or potentially pay a tax/penalty. If you opt-out of City medical coverage, you must choose coverage elsewhere (e.g. spouse's plan, Exchange/Marketplace coverage, Medicare, Medicaid, military, AHCCCS, another employer coverage or other qualified medical coverage).

DEPENDENT ELIGILBITY & VERIFICATION

You must verify/document the relationship status of the dependents you add to health plan coverage.
All required documentation is due within 31 days of your hire date or benefits effective date whichever is later (unless you elect a date of hire start date for eligible benefit plans, in which case all required documentation must be provided on your hire date). If not received timely, your dependent cannot be added to coverage and you must wait until the next Open Enrollment or a future qualifying event to make changes. Dependent eligibility verification documentation includes:

Eligible Dependents and Required Documentation

- **Your Legal Spouse** – marriage certificate
- **Your natural, adopted, foster or legal guardianship children under age 26** – birth certificate; foster, adoption, or legal custody papers
- **Your step-child(ren)** (natural, adopted, foster or legal guardianship children under age 26, of your legal spouse) - birth certificate, adoption/foster/legal guardianship papers, natural parent's divorce decree, your marriage certificate)
- **Committed Partner and Committed Partner child(ren)** – Affidavit/Declaration of Committed Partnership signed by both parties (and notarized), verification of same household and relationship duration of at least 12 months and documentation from two sources that proves you and your Committed Partner's financial inter-dependence; CP children verification documentation same as for step-child(ren).

Social Security Number Requirement

To comply with federal law, social security numbers for employees, spouse, children and other eligible dependents must be entered into the online enrollment system to complete enrollment. If you have a dependent without a SSN please contact the Employee Benefits Office for assistance.

Disabled Adult Dependent Child

A Disabled Adult Dependent Child may be covered if they are an unmarried dependent child age 26 or older who is permanently and totally disabled, with a disability that existed prior to the attainment of age 26. "Disabled" means the inability of a person to be self-sufficient and self-supporting as the result of a physical or mental condition **and** eligible for a Social Security Disability Award. The Plan requires proof of Social Security Disability annually during Open Enrollment. A Dependent Child who is not covered under the Plan but becomes disabled after reaching the Plan's Dependent age limit is not eligible to enroll as a Dependent under this Plan.

Committed Partner

Adding a Committed Partner to coverage requires forms and procedures for both you and your Committed Partner. There are some significant tax consequences to you when you add a Committed Partner to coverage (payroll deductions for medical, dental or vision coverage are taken post-tax and there is an imputed income to you – with tax withholding each pay-check – for the value of the coverage provided to your Committed Partner). Seek advice from your tax professional to determine what is best for your specific circumstances.

Note - acquiring a new CP and CP children mid-year is not an eligible qualifying event to add them to coverage or remove yourself from coverage. If you don't enroll your eligible CP and CP children (if applicable) as a new hire, the next opportunity to do so is during an Open Enrollment period .

When You, Your Spouse or Dependent Work for the City (Enrollment Rule)

If you or your spouse and/or a dependent adult child are benefit eligible employees of the City, you may each elect your own individual (single) plan coverage, or one employee may elect a family plan for themselves and the other employee spouse and/or dependent adult child(ren). The employee enrolled as the spouse of another employee must opt out of coverage as an individual. Dependent adult children covered under a parent City employee must opt out of their individual plan. This enrollment rule also applies to voluntary/supplemental life insurance coverage as well. You and your spouse or adult dependent child(ren) who are also City employees, cannot be enrolled in dual life insurance coverage. How you handle voluntary life insurance coverage does not have to be the same as how you handle medical, dental and vision coverage, but the general rule is that between the two (or more) employees in the same family you cannot have partial/full duplication of coverage or "double" coverage with the City.

Network and Claims Administration for Employees, Retirees or Dependents Living Out-of-State of Arizona

If you or at least one eligible dependent reside at least 4 months out of the year outside Arizona, you may enroll the entire family in an Out-of-State (OOS) Medical plan option administered by Blue Cross Blue Shield of Arizona. If you enroll in an OOS Medical Plan, you continue to use the BCBSAZ network of providers in Arizona plus, you and your covered family members will have access to affiliated BlueCard network providers in other states.

Ineligible Dependents

Dependents that are no longer eligible under the health plans or supplemental life insurance policy must be removed from your coverage if: 1) a child is age 26 or more or, 2) the employee is legally separated or divorced from a covered spouse (including any covered stepchildren). If an employee continues to pay health and life insurance premiums for an ineligible spouse or children, no premium refunds are given for late cancellation of coverage and no claims are paid for an otherwise ineligible dependent. If claims have already been paid for an ineligible person/time period, the employee may be responsible to reimburse the ineligible claims amounts.

In-Network Coverage

It is important that members choose in-network providers in order to get the best benefit. When an individual uses a provider who is in the Blue Cross Blue Shield of Arizona (BCBSAZ) network for medical plans or in the Delta Dental of Arizona network for dental plans, both the Employee Benefit Trust and the member receive discounts. Additionally, there are not only network discounts that apply to billed charges for medical care, but also a higher percentage of those allowed charges are paid by the plan as compared to the percentage that is paid for out-of-network covered services. To use the network benefits under the plans most effectively:

- Check the AmeriBen website, www.myameriben.com or the Delta Dental of Arizona website, www.deltadentalaz.com for participating providers
- Make sure ALL providers involved in your care, such as the surgeon, anesthesiologists, assistant surgeons and the healthcare facility are in-network providers.
- If you or a covered family member live outside of Arizona, enroll in an Out-of-State Medical Plan to gain access to BCBS networks on a national basis

Instructions for Locating a Blue Cross Blue Shield of Arizona Provider

Use the BCBSAZ website to locate a medical provider/facility in the network:

1. Open an internet browser and go to www.azblue.com/chsnetwork
2. A "Find a Doctor" page will appear; enter the Zip, City, State and the Provider's name, specialty, facility, or keyword in the required fields and click on search

Out-of-Network Coverage

Out-of-network coverage is available for those members who choose to use a provider who is not in the BCBSAZ (or out-of-state BCBS affiliated) networks and the Delta Dental of Arizona (and other affiliated national) networks. However, out-of-pocket costs for using out-of-network providers may be substantially more for the member and for the Employee Benefit Trust. In addition, there are other increased costs for using out-of-network providers:

- No Medical Plan Out-of-Pocket Maximums - members who choose out-of-network providers will continue to pay all deductibles and coinsurance amounts, without reaching a point where 100% coverage becomes available for the balance of that calendar year
- Coinsurance will be calculated based on allowable (or reasonable and customary) costs for the out-of-network service; allowable for hospitals and surgery-center facility charges is no more than 200% of Medicare allowable charges - members will pay any costs billed by out-of-network providers above the allowable cost in addition to their coinsurance amount (potential "balance billing")
- Out-of-network emergency room visits will not be paid in-network if not a medically necessary true emergency
- Any out-of-network post-emergency follow up care will be covered at out-of-network rates

Precertification

- Required under all City of Mesa Medical Plans for certain covered services (both in-state and out-of-state)
- Ensures that hospitalizations, surgeries, and other procedures are medically necessary; does not ensure that the provider rendering services is in-network
- A physician or facility office may contact the plan on your behalf to pre-certify required services but ultimately the member is responsible for making sure required services have been pre-certified; failure to pre-certify will result in denial of claims

Utilization or Concurrent Review/Case Management

- Ensures that continuation of medical services is medically necessary
- Coordinates member care with other health care providers, such as home health agencies, durable medical equipment vendors, and others
- May also assist with discharge planning and advising members and medical providers of various options available under the plan
- For more detailed information about precertification, utilization management and covered/non-covered services, please contact AmeriBen at 855.258.6467 for in-state medical plans, and BCBSAZ at 1.800.232.2345 ext. 4320, for out-of-state medical plans, or refer to the City of Mesa Health Plan Document at www.mesaaz.gov/benefits.

Explanation of Benefits

An explanation of benefits (EOB) is a statement sent by a health insurance carrier/administrator to covered individuals, explaining what claims were submitted on their behalf and what medical or dental treatment and/or services were paid by the Plan. EOB's also identify the member liability if any, (deductibles, copays, co-insurance and balance-bill amounts as applicable). An EOB is created and mailed every time a claim is processed/paid through the medical and dental plans. These EOB's are also available through the respective TPA websites—you can elect to turn off the mailed versions in these websites if you prefer to receive your EOB's online only.

Qualified Family/Status Changes

Generally, the only time you can enroll or makes changes in coverage or add/drop dependents, is when you are initially eligible for the benefit plan as a new hire (or newly transferred/promoted into a benefit eligible position), other times during the year with a qualified family status change, or during the next available Open Enrollment period. Requested changes must be consistent with the qualifying event. The employee is responsible for making appropriate benefit enrollment changes within 31 days of a qualifying event. If you don't make changes within that timeframe you may have to wait until the next Open Enrollment period to process the change. If the change is due to loss of eligibility of either you or a family member to participate in the Plan, you will incur liability to the Plan to pay back any overpayment that occurred between the date coverage should have terminated and the date you notify Benefits that you or dependent is no longer an eligible participant. Some changes in status include:

- Marriage
- Divorce
- Birth, adoption or legal custody of a child
- Death of dependent (spouse or child)
- Spouse or dependent loses or gains coverage eligibility due to change in employment
- Spouse of dependent's open enrollment period

Our medical, dental, vision and FSA plans are offered on a pre-tax basis under Section 125/129 of the IRS code (except for Committed Partner coverage). Because the IRS allows a tax advantage, there are certain rules governing those benefits. So not only do you get a tax advantage on the income used to pay for these payroll deductions/premiums, but you can also make changes during the year with a Qualified Family/Status Change. Changes that are consistent with the approved status change include:

- Enrolling in or opting out of coverage
- Adding or removing dependents
- Changing your FSA elections

IMPORTANT NOTICE: A new spouse, newborn, fostered or adopted/legal guardian children do not automatically have coverage even if you otherwise have family coverage in place. If you have or anticipate a status change, contact the Employee Benefits Office at 480. 644.2299 to process the necessary changes within 31 days of a qualifying event like marriage, birth/adoption, loss of other employer's coverage and within 60 days of a qualifying event due to death, legal separation/divorce or aging out of a dependent child.

HIPAA Compliant Medical, Dental and Vision Plans

Employee Benefits Administration and staff and respective Third Party Administrators, adhere to the strict privacy and confidentiality requirements under The Health Insurance Portability and Accountability Act (HIPAA) because it is the law, and because we value employees' privacy.

HIPAA Privacy and Security Rules require administrators to protect individually identifiable health information (PHI) and only use/release this information for plan related, defined purposes only. You and/or your covered adult family members can authorize the disclosure of PHI to a "personal representative" such as each other, and/or an organization. This allows access to health plan information about other covered family members and vice versa (e.g. coverage and claims status, EOB's, etc.). Members must complete authorizations for release of PHI under the respective medical and dental plans with each TPA (AmeriBen, BCBSAZ or Delta Dental of Arizona). You can initiate any PHI release authorizations you and adult covered members want, by contacting customer service or the website member portal with each administrator.

City of Mesa is contracted with a third party administrator (TPA) AmeriBen, to deliver our medical benefit program to you. They offer customer service hours Monday thru Friday from 7am to 6pm (except Holidays) and a state of the art employee portal website with dozens of tools to help you and your family navigate your healthcare needs.

AmeriBen provides: customer service, claims and appeals administration, utilization management (pre-cert and case management), disease management programs, medical/prescription drug ID cards and member website access for medical plan information, EOB's etc. The Customer Service phone number for the medical plans is 855. 258.6467 and the web portal www.myameriben.com for information and medical claims activity. This is the website to access Explanation of Benefits (EOB)'s and PPO Provider directories.

WHICH PLAN IS RIGHT FOR YOU?

The best medical plan for you depends on a number of factors:

- Who do you want to cover (dependents, locations, etc.)?
- What level of payroll deductions fit your budget?
- What can you afford to pay out-of-pocket (in terms of applicable deductibles, copayments and co-insurance amounts) if you or a covered dependent needs medical care?

2016 Medical and Rx Plan—Monthly Employee Premiums

Tier	Basic Choice Plan	Choice PPO Plan	Copay Choice Plan
Full-Time Employees			
Employee Only	$0.00	$106.00	$159.00
Family	$0.00	$235.00	$478.00
Part-Time Benefit Eligible Employees			
Employee Only	$80.00	$264.00	$317.00
Family	$188.00	$612.00	$855.00

2016 Medical Plan—Highlights

Medical Features	Basic Choice Plan		Choice PPO Plan		Copay Choice Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	$550/ Individual $1,650/ Family	$1,000/ Individual $3,000/ Family	$300/ Individual $900/ Family	$1,000/ Individual $3,000/ Family	$0	$1,000/ Individual $3,000/ Family
Coinsurance (Plan Pays)	50%	25%	80%	60%	N/A	60%
Out-of-Pocket Maximum (Includes deductible)	$4,500/ Individual $9,000/ Family	None	$2,450/ Individual $7,200/ Family	None	$3,425/ Individual $6,850/ Family	None
Physician Office Visit	$20 copay	25% after deductible	80% after deductible	60% after deductible	$20 copay	60% after deductible
ER Visit	50% after deductible	50% after deductible	80% after deductible	80% after deductible	$100 copay ($200 if admitted)	$100 copay ($200 if admitted)
Alternative Health Care (acupuncture, naturopath, homeopath)	Not Covered	Not Covered	80% after deductible, up to $1,000/year	60% after deductible, up to $1,000/year	Not Covered	Not Covered
Preventive Care & Immunizations	100%	Not Covered	100%	Not Covered	100%	Not Covered

SAMPLE COMBO MEDICAL/Rx ID CARD FOR IN-STATE MEDICAL PLAN

IN-STATE MEDICAL/PRESCRIPTION DRUG INSURANCE CARD AND ID NUMBER

Medical identification card information is combined in one card with prescription drug identification information and mailed to covered employees by AmeriBen. The same identification card is also applicable to your covered dependents, although only the employee/retiree's name is printed on the card.

- Always take your medical/prescription drug ID card with you when visiting a healthcare provider office or facility or when filling a prescription at a retail pharmacy
- The 5-digit ID number on the "medical" side of your identification card is your medical plan ID number (and it is also your COM employee ID number followed by MES); use this and the other information about the COM plan when filling out forms at a healthcare provider's office or facility
- The 9-digit alpha numeric number on the "prescription" side of your identification card starts with "RX00" and ends with the same 5-digit number you use for medical plan identification; use this 9-digit number when filling a prescription at a retail pharmacy or at mail order
- Claims submitted with incorrect information may be delayed or denied
- Please order replacement cards (or additional cards for other covered family members) through the AmeriBen website www.myameriben.com or Customer Care at 855.258.6467

GENERIC AND BRAND NAME DRUGS COVERED UNDER THE PLAN

The plan covers most FDA approved/indicated generic, formulary brand-name (preferred) and non-formulary brand-name (non-preferred) drugs:

- 30-day supplies can be purchased at any in-network pharmacy at retail copay and coinsurance prices
- 90-day supplies can be purchased exclusively in a retail location at any CVS/pharmacy or at a CVS/Caremark mail order pharmacy - both at "mail order" copay and coinsurance prices
- Specialty medications (whether generic, preferred brand or non-preferred brand name) must be purchased through the CVS/Caremark Specialty Pharmacy (in up to 30-day supplies only)

If a generic drug is available and the member or physician refuses substitution to generic, regardless of the reason:

- The member will pay the appropriate brand name drug coinsurance or copay PLUS,
- The difference in cost between the generic and brand name drug

Some drugs require prior authorization, have step therapy requirements or have quantity limitations. Members who have questions about whether and how, specific drugs are covered, should contact CVS/Caremark at 855.264.5048.

There are "step-therapy" and/or prior authorization requirements for certain classifications of Specialty Drugs – auto-immune drugs (rheumatoid arthritis), multiple sclerosis treatments and growth hormone treatments. These Specialty Drug classifications will restrict coverage to certain "preferred" Specialty Drugs only. Step therapy and/or medical necessity review is required for coverage of "non-preferred" drugs in these specific Specialty classifications.

100% covered preventive vaccinations for children and adults (including seasonal flu vaccinations) are available in-network through a participating "vaccinating pharmacist" under the pharmacy benefit. (Vaccinations are also available through an in-network physician's office or in-network retail medical clinic under the medical benefit as well.) The broader vaccination network for pharmacy is not as large as the regular pharmacy network, but does include many of the big chains like CVS, Walgreens, Costco, supermarket/store pharmacy locations and many independent pharmacy locations. Check store signage or call ahead to confirm vaccine availability, dispensing hours and other processes with the use of your CVS/Caremark Prescription Drug ID Card.

For detailed information on prescription drug coverage refer to the City of Mesa Plan Document at www.mesaaz.gov/benefits.

Rx Services	Basic Choice Plan	Choice PPO Plan	Copay Choice Plan
Out-of-Pocket Maximum (Separate from Medical)	$2,350/ Individual $4,700/ Family	$4,400/ Individual $6,500/ Family	$3,425/ Individual $6,850/ Family
Annual Deductible	$250	$50 (Waived on Generic and all Mail order)	None
Retail Supply– 30 Day			
•**Generic**	20% (min $5 max $50)	20% (min $5 max $50)	$10
•**Preferred Brand**	25% (min $30 max $100	25% (min $30 max $100)	$40
•**Non-Preferred Brand**	40% (min $50 max $200)	40% (min $50 max $150)	$75
Mail Order Supply– 90 Day			
•**Generic**	20% (min $10 max $100)	20% (min $12.50 max $100)	$20
•**Preferred Brand**	25% (min $50 max $200)	25% (min $75 max $200)	$80
•**Non-Preferred Brand**	40% (min $80 max $300)	40% (min $125 max $300)	$150

OUT-OF-STATE MEDICAL PLAN

Blue Cross Blue Shield of Arizona (BCBSAZ) is our Out-of-State Medical Plan (OOS) TPA, for those City of Mesa employees, retirees or dependents who have at least have one family member (or themselves) live outside the state of Arizona for the majority of the time. BCBSAZ provides utilization management (pre-certification and case management), disease management services, and allows eligible out-of-state members to use affiliated BCBS providers throughout the United States, including hospitals, urgent care centers, doctors and specialists. Prescription drug benefits for OOS medical plan members are through CVS/Caremark. The OOS medical network is only for those covered persons and their covered families, where at least one person regularly lives outside Arizona. **It is not for members who reside in Arizona who are traveling outside the state.**

The effective date of coverage for a member/family initially enrolling themselves or the family unit in out-of-state coverage will be the benefits effective date of the employee. The effective date of coverage for a change of coverage due to moving out-of-state will always be the first of the month immediately following or coincident to the timely change notification/enrollment. **An out-of-state enrollment change will result in a new plan/group number, member identification number for the family unit and new medical and prescription ID cards**. Deductibles, co-insurance, out-of-pocket maximums and other plan accumulators do not transfer when moving from the in-state plan to the out-of-state plan and vice versa.

There is no additional charge to enroll in the out-of-state plan. Out-of-state dependents not enrolled will only be covered under the out-of-network benefit of the in-state member's benefit plan. For out-of-state members who use a BCBSAZ contracted provider, services will be processed as in-network for the plan selected. For example, if a member is enrolled in the Choice 80/20 plan, services rendered by a BCBSAZ provider will first be subject to a $300 per person annual deductible, and then paid at 80% of the allowed network charges. If a non-network provider is used by a Choice member, or if the member is not enrolled in the BCBSAZ out-of-state plan (but is residing out-of-state), services will be processed as out-of-network (subject to a $1,000 deductible, then paid at 60%). To find an Out-of-State BCBSAZ Provider, call Blue Cross Blue Shield of Arizona at 866.288.5788 and state your OOS Plan member ID number and group number. You can also log in to Blue Cross Blue Shield's web site to do a provider search:

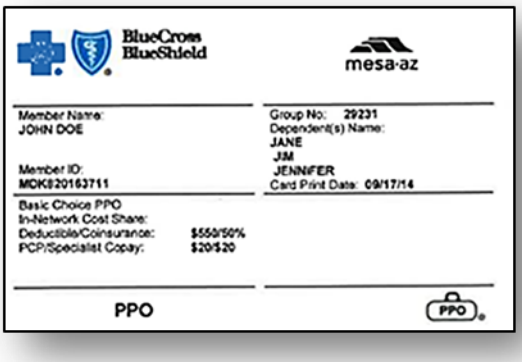
- Visit the provider directory at www.azblue.com
- Choose the tab for "Find a Doctor"
- Enter desired criteria to begin the search

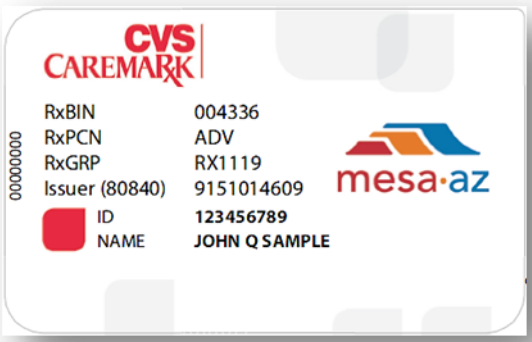
For detailed plan information and a list of exclusions and limitations, please refer to the City of Mesa Plan Document available at www.mesaaz.gov/benefits.

Out-of-state (OOS) members have two ID cards issued: one for the OOS medical plan issued by BCBSAZ (who is also the medical claims administrator for OOS members) and one for prescription drug benefits issued by CVS/Caremark; the ID number on both cards is a 9 to 12 digit number generated by BCBSAZ

Prescription drug benefits are available under the various City medical plans and administered by CVS/ Caremark (for both in-state and out-of-state plans). For locations of network pharmacies or information on which types of drugs are covered, contact CVS Caremark at 855.264.5048 or visit www.caremark.com.

SAMPLE ID CARDS FOR OUT-OF-STATE MEDICAL PLAN





DENTAL PLAN

City of Mesa offers dental plan coverage through Delta Dental of Arizona. Members have access to Delta Dental's PPO Network, which means access to network discounts and reduced costs for your dental services*. If your dentist is not a Delta Dental provider, no problem—you can continue to see them for services on an out-of-network basis. On the other hand, if your dentist is in the Delta Dental network or you choose to go to a Delta Dental dentist, you have an opportunity for reduced out-of-pocket expenses (provider discounted rates) as compared to a non-Delta Dental provider.

For a list of Delta Dental's PPO Network providers, call 602.588.3981, or go to www.deltadentalaz.com.

WHICH PLAN IS RIGHT FOR YOU?

The best dental plan for you depends on a number of factors:

- What are your anticipated dental expenses for the coming year?
- Will you be participating in the Health FSA?
- Do you or your dependents need orthodontia (braces)?
- Do you or your dependents need dental coverage beyond preventive and basic services?

2016 Dental Plan—Monthly Employee Premiums

Full-Time Employees

Tier	Preventive Choice Plan	Dental Choice Plan	Dental Choice Plus Plan
Employee Only	$0.00	$9.50	$24.50
Family	$6.00	$34.00	$114.00
Part-Time Benefit Eligible Employees			
Employee Only	$38.00	$47.50	$62.50
Family	$57.00	$85.00	$165.00

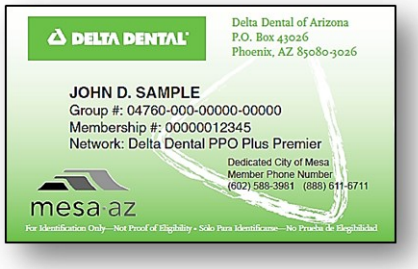
2016 Dental Plan—Highlights

Dental Features	Preventive Choice Plan	Dental Choice Plan	Dental Choice Plus Plan
Annual Deductible	• No deductible for preventive and diagnostic services • $50 deductible per individual on basic and major services • Family deductible will not exceed $150		
Preventative	100%		
Basic	80%		
Major	Not Covered	80% after deductible	
Orthodontia	Not Covered		80% up to $1,500 per year; $3,000 lifetime
Annual Max	$700 per person	$1,700 per person	$2,000 per person

For detailed plan information, please refer to the City of Mesa Plan Document available at www.mesaaz.gov/benefits.

*Note: Although the co-insurance percentages, deductibles and annual maximums are the same in each plan, regardless of whether you use an in-network or out-of-network provider, the allowable charges for in-network are based on DDAZ's discounted rates and the allowable charges for out-of-network are based upon reasonable and customary fee schedule that may result in balance billing to you, in addition to any deductible or co-insurance amount that you may have.

SAMPLE ID CARD FOR DENTAL PLAN



VISION CARE PLAN

Vision Services Plan (VSP) insures and administers our routine vision care and materials plan. Under this plan you have two options from which to choose, both with access to VSP's Choice Network, providing you with copays and discounted rates on services, vision materials (e.g. eye glasses or contacts) and no claim forms to complete. You can visit an out-of-network provider, but it may result in higher out-of-pocket costs and you will need to submit a claim for reimbursement. For a list of VSP Choice Network providers, call 800.877.7195, or go to www.vsp.com.

WHICH PLAN IS RIGHT FOR YOU?

The best vision plan for you depends on your specific needs. Since both plans are very similar in coverage, it really comes down to how often do you or your dependents need to replace your frames and lenses or buy more contacts. Both plans cover eye exams once every calendar year. The Vision Plus plan allows for lenses and frames once every calendar year as well, as opposed to only once every two calendar years under the Basic Vision Plan.

2016 Vision Plan—Monthly Employee Premiums

Full-Time and Part-Time Benefit Eligible Employees

Tier	Basic Vision Plan	Vision Plus Plan
Employee Only	$1.00	$4.93
Family	$7.65	$18.45

2016 Vision Plan—Highlights

Vision Features	Basic Vision Plan		Vision Plus Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Frequency of Services • Exams • Lenses • Frames • Contact Lenses	• Once every calendar year • Once every other calendar year • Once every other calendar year • Once every other calendar year		• Once every calendar year • Once every calendar year • Once every calendar year • Once every calendar year	
Well Vision Exam	$10 copay	Up to $45 allowance	$10 copay	Up to $45 allowance
Lenses • Single • Bifocal • Trifocal • Lenticular	$10 copay	• Up to $40 allowance • Up to $60 allowance • Up to $80 allowance • Up to $100 allowance	$10 copay	• Up to $40 allowance • Up to $60 allowance • Up to $80 allowance • Up to $100 allowance
Lens Enhancements • Standard/Custom/Premium • UVA/UVB Coating • Polycarbonate Lenses	• Available at a discount • Available at a discount • $10 copay ($0 for children under 18)	N/A	• Available at a discount • $10 copay • $10 copay ($0 for children under 18)	N/A
Frames	• Up to $130 allowance	• Up to $70 allowance	• Up to $130 allowance	• Up to $70 allowance
Contact Lenses In lieu of eye glasses • Fitting and Evaluation • Elective • Medically Necessary		• Up to $60 copay • Up to $200 allowance • $10 copay		

For detailed plan information and a list of exclusions and limitations, please refer to the City of Mesa Plan Document available at www.mesaaz.gov/benefits.

TO FILE AN OUT-OF-NETWORK CLAIM:

Submit an itemized receipt to the following address, with the covered member's ID number, name, address, phone number, patient's date of birth and relationship to member:

VSP
Attn: Out-of-Network Claims
PO Box 997105
Sacramento, CA 95899-7105

VOLUNTARY SHORT TERM DISABILITY (STD) PLAN

The Hartford provides a fully insured Voluntary Short Term Disability (STD) coverage for the City of Mesa. STD coverage is voluntary and available to full time employees only. You must actively enroll when you are first eligible (or in a subsequent open enrollment period). This benefit helps provide income protection if you're unable to work due to a non-work related disabling condition. The benefit will pay you 66.66% of your base weekly income, with a minimum weekly benefit of $25 and a maximum weekly benefit of $2,000. STD benefits are payable for a maximum of 6 months. Benefits begin after you have satisfied a waiting period while disabled as described below. During the waiting period, you may use accrued leave as outlined in the City of Mesa Personnel Rules. All sick and vacation accruals will be frozen while you are receiving STD benefits.

PLAN OPTIONS

- 7 Day Waiting Period for Benefits
- 29 Day Waiting Period for Benefits
- 44 Day Waiting Period for Benefits

If you are a new hire or electing STD for the first time, you will be subject to a pre-existing condition exclusion. This simply means if your disability was pre-existing 3 months prior to joining the plan, your claim may be denied. A pre-existing condition means any injury or sickness for which you received medical treatment, advice or consultation, care or services including diagnostic measures, or had drugs or medicine prescribed or taken The pre-existing exclusion will no longer apply after 6 months of coverage in the plan (if you were to become disabled as a result of that condition after that exclusion period is over).

VOLUNTARY SHORT TERM DISABILITY PLAN – MONTHLY EMPLOYEE PREMIUMS

The cost and benefit amounts for the Voluntary STD Plans can be calculated using the online eBenMesa Open Enrollment calculator. You may also manually calculate your weekly benefit and monthly premium by using the following formula:

Plan Option Waiting Period	Monthly Cost per $10 of weekly benefit
7-Day	$0.364
29-Day	$0.177
44-Day	$0.146

_____	/ 52 =	_____	X .6667 =	_____	/ 10 =	_____	X	_____	=	_____
Your annual earnings		Your weekly earnings		Your benefit max = $2,000				Rate from above based on desired Waiting Period		Your Monthly Premium

LONG TERM DISABILITY (LTD)

Long Term Disability (LTD) coverage provides you with a monthly benefit designed to partially replace income lost during periods of total disability resulting from a covered injury, sickness or pregnancy. Program benefits include:

ASRS MEMBERS

LTD is provided as a benefit under the pension/retirement program with the Arizona State Retirement System (ASRS). ASRS has contracted with Sedgwick Claim Management Services, Inc. (Sedgwick CMS) for administration of this Long Term Disability (LTD) Income Plan. Sedgwick CMS makes all decisions regarding claims submitted under the LTD Plan. The cost of this program is shared between the participant and the City of Mesa. **This is a mandatory benefit program—you will be automatically enrolled in this program when you are first eligible**. Coverage is 66.67% of your base salary after a waiting period, less any other compensation that you may receive.

PSPRS MEMBERS OR ELECTED OFFICIALS

The City of Mesa provides long term disability coverage with Reliance Standard Life Insurance Company (RSLI) for its sworn firefighters and police officers, and elected officials. RSLI makes all decisions regarding claims submitted under the LTD Plan. The cost of this program is paid in full by the City of Mesa (no LTD enrollment application is necessary). Coverage is for 60% of your base salary after a waiting period, less any other compensation that you may receive. Please note this is a separate benefit from the Public Safety disability retirement benefit (ordinary, temporary and accidental) that is also provided to eligible sworn firefighters and police officers.

For detailed plan information and a list of exclusions and limitations, please refer to the City of Mesa Plan Document and Policy/Certificates available at www.mesaaz.gov/benefits.

LIFE AND AD&D INSURANCE

BASIC LIFE AND AD&D INSURANCE

The City of Mesa provides full-time employees with Basic Life Insurance and Accidental Death & Dismemberment coverage equal to one times your annual salary through Reliance Standard Life Insurance Company, at no cost to the employee. (Elected Officials, City Manager and Executive Pay Plan employees may be eligible for different amounts of Basic Life and AD&D Insurance coverage as described in the City of Mesa Health Plan Document).

BUSINESS TRAVEL ACCIDENT/COMMUTER TRAVEL LIFE INSURANCE

Full-time employees are also provided with Business Travel Accident/Commuter Travel Accident Life Insurance coverage equal to $200,000 in the event the employee dies as a result of an accident that occurs while traveling on City business or directly commuting to or from work. This benefit is provided through The Hartford Life Insurance Company, also at no cost to the employee.

SUPPLEMENTAL LIFE INSURANCE

Both full-time and part-time benefit eligible employees may purchase Supplemental Life Insurance for themselves and their spouse/committed partner and/or eligible children (up to age 26), through Reliance Standard Life Insurance Company. Coverage for employees and spouse/committed partner is available up to a total of $300,000 each (eligible children up to $10,000). You, your spouse, and/or dependents cannot be enrolled in dual life insurance coverage with the City of Mesa.

If you enroll as a new hire you have a guaranteed issue amount of $100,000 for the employee and $30,000 for your spouse without having to complete an Enrollment and Statement of Health (ESH) Evidence of Insurability form. This means you will not be denied insurance for medical reasons up to those amounts.

If you do not enroll as a new hire you can add or increase coverage during Open Enrollment or due to a qualifying life change. Please be advised that you would need to fill out an ESH form and your application will be subject to medical review and approval by the carrier administering this plan.

This coverage may be portable should a covered employee terminate employment with or retire from the City of Mesa. Please refer to the Life Insurance Certificate of Coverage for more information.

For detailed plan information and a list of exclusions and limitations, please refer to the City of Mesa Plan Document and Policy/Certificates available at www.mesaaz.gov/benefits.

COST OF SUPPLEMENTAL LIFE INSURANCE

Age Band (Employee or Spouse)	Cost per $1,000 of Coverage per Month
< 29	$0.04
30-39	$0.06
40-44	$0.12
45-49	$0.24
50-54	$0.34
55-59	$0.56
60-64	$0.78
65-69	$1.36
70-74	$2.10
75-79	$3.00
80+	$5.80
Child(ren)	
All eligible children up to age 26 can be covered for one single flat amount	$1.00/month for $10,000 of coverage

BENEFICIARIES

You are required to be and are automatically the beneficiary for any life insurance proceeds on your spouse, committed partner or children.

However, you may designate beneficiaries for your own life insurance coverage. If you fail to make these designations, benefits will be paid in accordance with carrier rules, in the following order to your surviving family members:

- Spouse
- Child(ren)
- Parents
- Siblings
- Estate

Update or designate your beneficiaries on eBenMesa.

Ineligible Dependents

Dependents that are no longer eligible under the health plans or life insurance policy should be removed from your coverage if:

1. The child is age 26 or more
2. The employee divorces from a covered spouse (including any covered stepchildren).

If an employee continues to pay life insurance premiums for an ineligible spouse or children no premium refunds are given for late cancellation of coverage; even if premiums are paid in error no claims will be paid for.

HEALTH AND DEPENDENT CARE FSA

ConnectYourCare (CYC) is the City's TPA for our Flexible Spending Accounts (FSA). CYC services include: 24/7/365 call center, Health FSA debit payment cards, member portal website, mobile app and multiple claims submission and substantiation options. All this information is available at www.connectyourcare.com or by calling 844. 226.1872.

The FSA Plan offers employees the opportunity to set aside pre-tax dollars from their paychecks to pay for certain eligible health care and/or dependent care (child or elder care) expenses that would normally be paid out of your own pocket on an after tax basis. When you enroll in the flexible spending account program, you reduce your tax liability by reducing your taxable income. If you receive reimbursement for an expense from one of the flexible spending accounts, you cannot claim that expense as a deduction or take a federal income tax credit on your personal income tax return. Claims may be submitted for reimbursement up to 90 days after the end of a calendar year in which you are enrolled. **The deadline to submit FSA claims for expenses incurred January 1, 2016 through December 31, 2016, will be March 31, 2017, by 6:00 p.m.**

Flexible Spending Accounts (FSA) is a use-it-or-lose-it benefit (under IRS regulations) so estimate your expense carefully. The health flexible spending account plan does however have a "$500 Rollover" plan feature. With this feature, you can rollover up to $500 of your unclaimed health FSA balance to the following plan year. This rollover amount is in addition to whatever you elect during Open Enrollment for the next plan year. All other unused amounts over the $500 will be subject to the use-it-or-lose it rule.

There is a minimum annual election amount of $100 (for each health and dependent care FSA's). Employees do not need to be enrolled in the City's health plan to enroll in a Flexible Spending Account. Members who have single coverage under the City's health plan can also request health expense reimbursements for their dependents in their FSA. Expenses must be incurred by you or a qualified dependent (generally legal spouse and dependent children under IRS rules). You cannot submit health or dependent care FSA expenses for a Committed Partner or Committed Partner children.

Note that IRS regulations require re-enrollment into the FSA each year during Open Enrollment. In other words, if you intend to participate and contribute towards a health and/or dependent care FSA for the following calendar year, you MUST enroll during Open Enrollment, otherwise your elections will default to $0 starting on January 1.

HEALTH FLEXIBLE SPENDING ACCOUNT

The Health FSA plan allows you to set aside up to $2,500 each calendar year to pay for eligible health care expenses that are not covered by your health insurance including deductibles, coinsurance, copayments, and certain items not covered by insurance.

In accordance with Health Care Reform (ACA) requirements, over-the-counter (OTC) medicines and products require a Physician prescription in order to be reimbursed under a Health FSA account. The physician prescription must be submitted each and every time the OTC medicine or product is claimed for reimbursement under the Health FSA. For more information on eligible and ineligible expenses, please refer to the Plan Document.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

The Dependent Care Flex Plan allows you to set aside up to a maximum of $5,000 per married couple or single adult in 2016 to pay for eligible child or elder care services that are needed so you and your spouse (if applicable) can work, look for work or attend school full-time. Tuition for educational expenses (whether private or public) for children in kindergarten to age 13 is not eligible for reimbursement. Once you incur expenses for certain qualifying childcare expenses, you can submit those receipts for reimbursement from this account. Reimbursements made from this account will be equal to the amount of the claim, but not more than the balance currently in your Dependent Care Account.

Dependent Care arrangements, which qualify include:

- A Dependent (Day) Care Center, provided it complies with applicable state and local laws if care is provided by the facility for more than six individuals;
- An education institution for pre-school children.
- For school-age children (Kindergarten through age 12), only expenses for before & after school care are eligible; tuition fees do not apply.
- An "individual" who provides care inside or outside your home who is not your child under age 19 or anyone you claim as a dependent for federal tax purposes (i.e., spouse).

The Dependent Care Flexible Spending Account is for qualified elder care or day care expenses ONLY. You cannot claim dependent medical/dental expenses on the Dependent Care Flex Account.

FSA CLAIMS

All claims will be reviewed for eligibility and accuracy. Please hold onto your receipts in case you are asked to substantiate your claim.

For Health Care FSA claims not paid using your debit payment card and all Dependent Care FSA claims, follow these easy steps to enter a claim:

- Log into your account online or on the mobile app, CYC Mobile.
- Click to add a new reimbursement request, and follow the easy steps on the screen to enter information about your claim.
- Continue through the screens and submit the required documentation via documentation upload or by fax.

FSA HEALTH CARE DEBIT CARD PAYMENTS

When you use your debit payment card to pay for eligible health care expenses, there is no need to file a claim online. Card charges automatically appear in your online account, but be sure to keep your itemized receipts in case they are requested later to substantiate your claim.

FSA SAVINGS

An FSA can save you up to 30% on qualified expenses, depending on your tax bracket. In the following example, we'll show how an employee who earns $35,000 a year with $1,500 in eligible healthcare expenses could save money using an FSA:

	With FSA	Without FSA
Annual pay $35,000	**$35,000**	**$35,000**
Pre-Tax contribution to FSA	**- $1,500**	**- $0**
Taxable income	**= $33,500**	**= $35,000**
Federal income and Social Security Taxes	**- $7,362**	**- $7,852**
After-tax dollars spent on eligible expenses	**- $0**	**- $1,500**
Spendable income	**= $26,138**	**= $25,648**
Tax savings with FSA	***$490**	**$0**

*Actual savings will vary based on the individual tax situation

For detailed plan information and a list of exclusions and limitations, please refer to the City of Mesa Plan Document available at www.mesaaz.gov/benefits

SAMPLE HEALTH FSA DEBIT PAYMENT CARD

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The City of Mesa provides Employee Assistance Program (EAP) coverage through ComPsych GuidanceResources to all employees (except seasonal employees). Personal issues, planning for life events or simply managing daily life can affect your work, health and family. EAP services provide support, resources and information for personal and work-life issues for both eligible employees and your household members at no charge. You or your family can access these services by calling 866.519.7415 or going online to www.guidanceresources.com and using company web id: **MESA.**

Below are some examples of how ComPsych GuidanceResources can help you and your family deal with everyday challenges.

Confidential Counseling

Someone to talk to.

This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face (up to 8 in person or telephonic visits per person, per issue, per year). The service is staffed by GuidanceConsultants—highly trained master's and doctoral level clinicians who will listen to your concerns and quickly refer you to in-person counseling and other resources for:

- Stress, anxiety and depression
- Relationship /martial conflicts
- Problems with children
- Job pressures
- Grief and loss
- Substance abuse

Financial Information and Resources

Discover your best options.

Speak by phone with our Certified Public Accountants and Certified Financial Planners on a wide range of financial issues, including:

- Getting out of debt
- Credit card or loan problems
- Tax Questions
- Retirement planning
- Estate planning
- Saving for college

Legal Support and Resources

Expert information when you need it.

Talk to their attorneys by phone. If you require representation, we'll refer you to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call about:

- Divorce and family law
- Debt and bankruptcy
- Landlord/tenant issues
- Real estate transactions
- Civil and criminal actions
- Contracts

Work-Life Solutions

Delegate your "to-do" list.

Their Work-Life specialists will do the research for you, providing qualified referrals and customized resources for:

- Child and elder care
- Moving and relocation
- Making major purchases
- College planning
- Pet care
- Home repair

GuidanceResources Online

Knowledge at your fingertips.

GuidanceResouces Online is your one stop for expert information on the issues that matter most to you...relationships, work, school, children, wellness, legal, financial, free time and more.

- Timely articles, HelpSheets, tutorials, streaming videos and self-assessments
- "Ask the Expert" personal responses to your questions
- Child care, elder care, attorney and financial planner searches

Just call or click to access your services

Your ComPsych GuidanceResources Program

CALL ANYTIME
Call: 866.519.7415
TDD: 800.697.0353
Online: guidanceresources.com
Your company Web ID: MESA

mesa·az | HEALTH & WELLNESS

The City of Mesa Health & Wellness Center offers primary and preventive care healthcare services exclusively to active employees and their family members who are enrolled in a City of Mesa Medical Plan. Medical professionals are certified and experienced family medicine providers, located at 1121 South Gilbert Road, Suite 101, Mesa, AZ 85204. Best of all, primary and preventive care services are be offered at no charge to eligible employees and covered family members. You can register and schedule an appointment at www.mesahealthandwellness.com or by calling 480.644.WELL (9355). Appointments are available Monday thru Thursday from 7:00 am to 6:00 pm and Friday from 8:00 am to 4:00 pm. Center staff can provide the same level of care you would find in any other family practice setting with excellent access and convenience and no charge to the patient. Exams and procedures at the Center include, but are not limited to the following:

Health & Wellness Center Medical Services	
Preventive Care	Adult Annual Exams • Blood work • Vaccines • Referrals for other screening tests (mammogram, colonoscopy) Well Child Exam • Newborn screening • Vaccines • Growth and Development • Kindergarten Exams
Episodic Care	*Examples* • Strep throat • Seasonal allergies • Ear infections • Sinus issues • Headaches • Kidney and urine problems • Infections • Skin conditions and infections
Disease Management	*Examples* • High blood pressure • Diabetes • Asthma • High cholesterol • Migraine headaches • Mood disorders
Procedures	*Examples* • Sutures/stiches and removal • Wart removal • Skin lesion removals • Skin biopsies • Ingrown toenail removal • Ear washing

REQUIRED NOTICES

BOTH THE EMPLOYEE AND THEIR COVERED SPOUSE SHOULD TAKE THE TIME TO READ THIS NOTICE CAREFULLY

VERY IMPORTANT NOTICE REGARDING CONTINUATION COVERAGE "COBRA"

On April 7, 1986, a federal law was enacted (Public Law 99-272, Title X) requiring that employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage" or COBRA) at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to summarize your rights and obligations under the continuation coverage provision of the new law.

If you are an employee or retiree of the City of Mesa covered by the City of Mesa Health Plan you have the right to choose continuation of coverage if you lose your group health coverage due to any of the following qualifying events having occurred:

1. Voluntary termination
2. Involuntary termination (for reasons other than gross misconduct)
3. Reduction of hours (strike, lay off, leave of absence, full time to part time)

If you are the SPOUSE of an employee or retiree covered by the City of Mesa Health Plan, you have the right to choose continuation of coverage for yourself if you lose your group health coverage due to any of the following qualifying events having occurred:

1. Death of the employee or retiree
2. Voluntary or involuntary termination (for reasons other than gross misconduct) of employment or reduction in hours of employment for the employee
3. Divorce or legal separation
4. Medicare Entitlement

In cases of a dependent child of an employee or retiree covered by the City of Mesa Health Plan, you have the right to choose continuation of coverage for yourself if you lose your group health coverage due to any of the following qualifying events having occurred:

1. Death of the employee or retiree
2. Voluntary or involuntary termination (for reasons other than gross misconduct) of employment or reduction in hours of employment for the employee
3. Divorce or legal separation
4. Medicare Entitlement
5. The dependent child ceases to be a covered dependent under the City of Mesa Health Plan guidelines.

Under the law, the employee or family member has the responsibility to inform the City's Employee Benefits Office of a divorce, legal separation, or child losing dependent status under the City of Mesa Health Plan guidelines. **The employee or family member must notify the Employee Benefits Office within 60 days of the qualifying beneficiary's loss of coverage due to one of the above-mentioned qualifying events.**

When the City of Mesa Employee Benefits Office is notified within 60 days that one of these events has occurred, the Employee Benefits Office will in turn notify you that you have the right to choose continuation of coverage. **Under the law, you have 60 days from the later of the date you would lose coverage or notification because of one of the events described above to notify the City of Mesa that you want continuation of coverage.**

If you do not choose continuation of coverage, your group health insurance coverage will end.

If you choose continuation of coverage, the City of Mesa is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. The new law required that you be afforded the opportunity to maintain continuation of coverage for three (3) years unless you lost group coverage because of termination of employment or reduction in hours. In that case, the required continuation of coverage period is eighteen (18) months. However, the new law also provides that your continuation coverage may be cut short for any of the following reasons:

1. Non-payment of the required premium by the due date, including any grace period, if applicable (coverage would terminate the first of the month for which the premium was not paid).
2. The City of Mesa ceases to provide health coverage to employees.
3. The date the covered person(s) becomes covered under another group health plan which does not limit coverage due to a pre-existing condition (including Medicare).
4. The person(s) becomes eligible for Medicare.
5. Expiration of the maximum continuation period (unless disabled-see below).

Special Instructions for disabled participants: If you (or your qualifying beneficiary) were determined to have been disabled under Title II or XVI of the Social Security Act as of the date of your qualifying event, then that disabled individual's coverage may not end until 29 months following the date of the qualifying event that caused the ineligibility for health care coverage. The cost of coverage for the 19th through the 29th months of coverage would be 150% of the applicable premium for non-disabled employees. Your plan administrator can provide exact prices.

To be eligible for this extension, you must provide the City of Mesa Employee Benefits Office with a copy of the Notice of Disability from the Social Security Administration. The Notice of Disability must be submitted within 60 days of the date of the notice, and before your 18 month COBRA period expires.

You do not have to show that you are insurable to choose continuation of coverage. However, under the law, YOU WILL **HAVE TO PAY THE ENTIRE PREMIUM** for your continuation of coverage, i.e., your portion as well as the portion previously paid by the City of Mesa along with the administration fees.

This law applies to City of Mesa Health Plan beginning on July 1, 1986. If you have any questions about the law, please contact the City of Mesa Employee Benefits Office at 20 E. Main St., Ste. 600, Mesa, AZ 85201 or call (480) 644-2299. Also, if you have changed marital status or you or your spouse have changed addresses; please notify the Employee Benefits Office as soon as possible.

The following documents are *links to informative articles and other required notices that must be provided to you:

- **Healthcare Reform Article**
- **Healthcare Exchange Letter**
- **HIPAA Privacy Notice**
- **Medicare Notice of Creditable Coverage**
- **Newborn's and Mother's Health Protection Act**
- **SBC's for City of Mesa Medical Plans**
- **State Children's Health Insurance Program (SCHIP)**
- **Women's Health & Cancer Rights Act**
- **COBRA Initial Notification**

*The documents and articles above are available in the following website: http://mesaaz.gov/about-us/jobs/benefits/federally-mandated-notices

The information in this workbook provides general information on programs and summaries of health benefits offered to City of Mesa members. All information is subject to change and is not a guarantee of benefits. For details about the plans, including who's eligible, what the plans cover, and exclusions and limitations, please refer to the City of Mesa Plan Document available at www.mesaaz.gov/benefits. This Guide provides an overview only. If there is a difference between the Guide and the City of Mesa Plan Document (or underlying policies/certificates), the Plan Document (or underlying policies/certificates) will prevail.

ADMINISTRATOR CONTACT INFORMATION

Topic	Contact	Call	Website
General Benefit Questions • Plan Sponsor/Administrator • Eligibility • eBenMesa Online Enrollment • COBRA • Retiree Health Plans • Medicare Part D • Life and AD&D Claims Process	**Employee Benefits Office**	**480.644.2299**	**www.mesaaz.gov/benefits**
Medical Plan (In-State) • Customer Service • ID Card • Claims Processing/EOB's • Appeals • Website Portal Questions • PPO Network Verification • Eligibility Verification • Pre-Certification • Disease Management	**AmeriBen** **24/7 Nurse Line (BCBSAZ)**	**855.258.6467** **866.422.2729**	**www.myameriben.com**
Medical Plan (Out-of-State) • Customer Service • ID Card • Claims Processing/EOB's • Appeals • PPO Network Verification • Eligibility Verification • Pre-Certification • Disease Management • Website Portal Questions	**BlueCross BlueShield of AZ** **24/7 Nurse Line**	**866.288.5788** **866.422.2729**	**www.azblue.com**
Prescription Drug Benefits • Customer Service • Preauthorization • Specialty Drug • Website Portal Questions • Claims Processing/Appeals	**CVS/Caremark**	**855.264.5048**	**www.caremark.com**
Dental Plan • Customer Service • ID Card • PPO Network Verification • Website Portal Question • Pre-Treatment Estimate • Claims Processing/Appeals	**Delta Dental of AZ**	**602.588.3981**	**www.deltadentalaz.com**
Vision Care Plan • Customer Service • PPO Network Verification • Website Portal Question • Claims Processing/Appeals	**VSP**	**800.877.7195**	**www.vsp.com**
FSA Plan • Customer Service 24 x 7 • Direct Deposit Payments • Health FSA Debit Cards • Claims Processing • Account Balances	**ConnectYourCare**	**844.226.1872**	**www.connectyourcare.com**
Short Term Disability • Customer Service • Claims Processing/Appeals	**The Hartford**	**800.549.6514**	**—-**
EAP • Customer Service • Website Portal Questions	**ComPsych**	**866.519.7415**	**www.guidanceresources.com** Web ID: MESA